REPORT OF BOARD OF TRUSTEES

BOT Report 12-A-16

Subject: Improving Network Adequacy and Out-of-Network Billing Policy

Presented by: Douglas W. Curran, MD, Chair

Referred to: Reference Committee on Socioeconomics

At the 2015 Annual Meeting, the Board of Trustees voted to establish a Task Force on Balance Billing with the following charge:

1. The Task Force shall study the issue of balance billing from both the patient perspective and the physician perspective and develop and/or recommend (1) policy; (2) advocacy options; and (3) TMA communications strategies. The Task Force shall report back to the Board of Trustees upon completion.

2. The Task Force held several meetings to review past TMA legislative and regulatory advocacy on balance billing and conduct research into physician and patient attitudes in regard to balance billing.

History of Network Adequacy/Balance Billing Advocacy

In 2000, the Texas Department of Insurance (TDI) began sending cease and desist letters to anesthesiologists who billed their patients for services. In the letters, TDI asserted that physicians who are granted privileges in the hospital implicitly agreed to accept discounted payments from insurers contracted with the hospital along with the promise to not bill the patient beyond those payments. Interestingly, this was contrary to some public statements made by the commissioner to consumers at the time through publications on how health insurance worked and the expenses for which consumers should expect to pay out of pocket.

TDI was unwilling to modify its argument that practicing on a hospital campus equated to an agreement to be bound by the hospital contracts. Rep. Bob Turner, then-chair of the House Committee on Public Safety, requested an attorney general (AG) opinion as to whether TDI had the authority to issue a cease and desist order against a physician for billing his patient and whether the HMO Act prohibits a physician from billing patients. TMA submitted a letter brief to the attorney general and secured a favorable attorney general opinion (GA-0040): “The HMO Act does not prohibit a physician without a contract from billing an enrollee. The Department of Insurance is not authorized to enforce the Act to prohibit such a physician from balance billing an enrollee of the HMO.”

The AG opinion instructed opponents that current insurance law was not equipped to prevent physician billing. In every session since 2003, at least one bill seeking to prohibit balance billing has been filed. Among the many bills filed, three major bills have passed. Senate Bill 1731 (Transparency and Estimates-2007), House Bill 2256 (Mediation and Rules on Network Adequacy-2009), and SB 481 (Modification of HB 2256 Threshold-2015). Over the past 15 years and eight legislative sessions, TMA has successfully turned the legislative and policy discussions and approach by those who have sought to “prohibit balance billing” to “requiring TDI to regulate network adequacy.”

In Texas, some strides were made after the passage of SB 1731 in 2007 regarding the incidence of out-of-network physician services at in-network facilities. As required by SB 1731, a TDI Workgroup on Network Adequacy was formed and reported the following in January 2007:
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- Ninety percent of the total facility-based provider claims/visits reported by five of the largest preferred provider benefit plans (PPBPs) and 85 percent of claims/visits provided by HMOs indicate services were delivered by in-network facility-based physicians.
- Health plans’ payment averages for both contracted and non-contracted providers varied, but one health plan in particular had significantly lower average payment rates for all types of providers.
- Among PPBPs, four of the five plans generally report higher allowable payments for non-contracted providers than for contracted physicians. One plan differs dramatically, often reporting non-contract allowances significantly lower than those for contract providers. In some cases, the health plan’s payment to the provider will be less than the allowable amount due to insured cost-sharing requirements.
- Compared to PPBPs, HMOs reported significantly lower non-network claims paid.
- The extent to which hospitals can coordinate patient care to ensure patients receive services from an in-network provider when possible is extremely limited; most hospitals are unable to coordinate such services due to scheduling issues and limited computer capabilities.
- Of all facility-based providers, emergency services represent the highest potential for balance billing in claims not paid by PPBPs, followed by anesthesiology and radiological services (data based on billed charges submitted by providers and allowed amounts paid by health plans).
- Based on data provided by the surveyed PPBPs, the total potential cost of balance billed services was $24.5 million (based on total billed charges of $88.4 million and total allowed charges of $56 million). These data do not include or reflect claims filed or benefits paid under self-funded benefit plans, which are excluded from state insurance regulation under the federal Employees Retirement Income Security Act (ERISA).

After the report, HB 2256 was enacted and commanded TDI to develop network adequacy standards for PPBPs (which at the time had no standards in place). As a result, then-Commissioner Mike Geeslin adopted comprehensive network adequacy regulations for the preferred provider market. Shortly thereafter, newly appointed Commissioner Eleanor Kitzman attempted to suspend those regulations by bulletin. In addition, Ms. Kitzman suspended utilization review regulations developed over two years and changed the course of draft Exclusive Provider Organization (EPO) regulations from patient-centric to carrier-centric provisions.

An intensive advocacy effort was undertaken. More than 140 pages of comments were submitted to TDI, which ultimately proved successful at maintaining the integrity of the regulations originally adopted by Commissioner Geeslin. In the meantime, to remain in her position as commissioner, Ms. Kitzman had to be confirmed by the Senate. The Senate Nominations Committee never brought her nomination forward for a vote, and she was not confirmed.

Current Texas Law and Standards
The Texas Insurance Code and the associated Administrative Code establish two payment standards for insurance companies to meet when settling claims out-of-network. The standards differ based on whether the network is closed (such as in HMOs or EPOs) or open (such as in PPBPs).

Under TDI regulation, for emergency claims and in circumstances where a network physician is unavailable, HMOs and EPOs must pay an amount sufficient to ensure a balance bill is not issued by the physician. This does not mean the HMO or EPO must pay a claim at the full billed charge, but instead means that it must settle the outstanding amount sufficiently to the point where a physician will not desire to seek any remaining balance amount from the covered person beyond the patient’s applicable copay, coinsurance, or deductible, and the payment from the HMO or EPO.
PPOs, because they have some out-of-network benefit, have a different standard. An insurer offering a PPO must pay a claim for out-of-network emergencies or when a preferred provider is not reasonably available, at a minimum, at the usual or customary charge for the service. The word “charge” is underscored as one may often hear about UCR payments by insurers. The Texas regulatory standard is not based on insurance company payments, but on physician charges. Also, readers will note that this is a minimum — carriers may choose to pay on a standard that is higher than UCR charges (although that scenario is extraordinarily unlikely).

The regulation continues to state that if out-of-network payments are made based upon usual, customary, and reasonable charges, that UCR charge amount must be based on generally accepted industry standards and practices for determining the customary billed charge for a service that fairly and accurately reflects market rates.

TDI developed these payment standards with the consumer (our patients) in mind. These are settlement obligations owed to the patient by the insurer. Although the standards, in the end, finance payment for physician services, they are intended to ensure consumers (our patients) receive insurance coverage out-of-network in exchange for the premium paid to the insurer. Without a contract between the physician and insurer, an insurer does not have an obligation to the physician.¹

**National Activity on Balance Billing**

As complaints about network adequacy spread across the nation due to the adoption of the managed care model in the Affordable Care Act (ACA), the federal government began to establish national network standards. The National Association of Insurance Commissioners (NAIC) asked the federal government to refrain from acting on a proposed national network adequacy standard until the NAIC modified its model act.

TMA has submitted three comment letters on NAIC’s model act (and has been present at many teleconference meetings) since 2014. The association encouraged NAIC to adopt a model act that would regulate tiered networks, ensure accurate directories, and provide consumer protections from insurer out-of-network claim settlement practices.

Unfortunately, the resulting model act contained little in the way of standards to be met by insurers. Indeed, America’s Health Insurance Plans and the Blue Cross Blue Shield Association embraced the final model in a joint, perfunctory two-page letter.

While there were few requirements imposed upon carriers in the model act, NAIC did impose a mandate on physicians in the form of a ban on balance billing under certain circumstances. The ban on billing states “the out-of-network facility-based provider shall include a statement on any remittance notice sent to the covered person for services provided informing the covered person that he or she is responsible for paying their applicable in-network cost-sharing amount, but has no legal obligation to pay the remaining balance.”

At this time, there is a bill filed in the United States Congress that aims to prohibit physician balance billing. That bill — HR 3770 — applies to all physicians who have privileges at a network hospital but do not have a contract with the same insurance companies as the hospital.

¹ State-regulated plans are required to recognize assignment of benefits. However, assignment is the transfer of a patient’s right to payment to the physician. ERISA employer plans are not required to recognize assignment.
Presidential candidate Hillary Clinton also has proposed to make changes to the ACA that would prohibit certain billing out-of-network. Ms. Clinton’s proposal addresses “surprise” medical bills, which, according to her campaign’s statements, have become an increasingly thorny problem as health plans with narrow provider networks become more common. Patients who visit in-network facilities for surgery, for instance, sometimes unwittingly receive services from a doctor who is not part of their network and end up with steep bills. Her plan would prohibit providers from charging at out-of-network rates when a patient visits a facility covered by their insurance plan.

**Political Realignment**

The enactment of the ACA has caused a political shift. Consumer groups, once allies of physicians and providers on matters of insurance and network adequacy, are now in political opposition on this issue. Consumer groups have aligned with insurers in efforts to ban physician billing. This likely is because consumer groups desire to bolster the benefits provided to consumers without an increase in premium. That has led them to conclude that a prohibition on the medical expense for which insurance is intended to pay offers a solution. In addition, NAIC failed to demonstrate any desire to regulate insurer networks proactively, preferring to prohibit balance billing by out-of-network physicians in their recently adopted model bill.

**Two Broad Policy/Regulatory Paths to Take**

The future calls on organized medicine to take one of two broad paths: Free Enterprise or Public Utility Regulation. American health care is at a crossroad. “On one road, Americans would seek better control over national health spending through an all-payer system, such as the one operated by Maryland… On the other road, Americans would seek better control of health care … spending through greater reliance on market forces for most of the health system.” The battle over policy “in the coming decades is likely over which road to take.” — Uwe Reinhardt, *Health Affairs*, 2009.

**Free Enterprise**

In a free enterprise model, providers increase supply in response to price, or price increases/decreases the quantity consumers demand for a product or service. Supply and demand are NOT always in equilibrium. That is why there are shortages and surpluses. It has been said, self-interest is the single, most powerful force in the U.S. economy. Consumers shop for the best possible goods at the lowest prices. Producers look for ways to make the largest possible profits. Producers often invent better products and develop more efficient ways to produce them. High profits may encourage producers to expand their businesses. That growth will make more goods available to consumers. In other words, efficiency increases supply.

Yet, over and over, one main complaint in health care is that the price of a service is not easily discernible by consumers in the marketplace. One may shop for health care, but it requires an investment in time. Many people enjoy shopping for clothes, gadgets, cars, and other desirable consumables. People do not enjoy shopping for health care.

Free enterprise as a model is possible for health care, but patients expect an easy method for comparing charges. (The word “charges” is used here to clarify this is not about estimates, contract rates, stipends, or providing a single amount for a treatment plan of any length.)

**Public Utility Regulation**

Investor-owned/privately owned utilities are primarily regulated at the state level, where public service commissions (PSCs) are responsible for overseeing and authorizing investment decisions, operations, and customer rates. Publicly owned utilities — such as rural cooperatives, municipal utilities, and federal or
state power authorities — are not generally regulated by state public service commissions. They are
overseen by their government organizer — the co-op boards, municipal governments, or federal entity.

There is no requirement that a rate-regulated industry constitute a de facto monopoly (natural monopoly).
De facto monopolies include water, cable television, Internet, telephone, and electricity. The capital costs
and infrastructure demanded by these industries are so high they bring barriers to entry. However,
insurance is an industry in which there is no natural monopolistic tendency — yet there is rate regulation.
The primary purpose of rate regulation in insurance is to ensure rates don’t go too low. In the early 20th
century, insurers would set very low rates to obtain market share — only to go insolvent when claims
were filed.

Insurance is considered an industry with “a public interest.” It brings certainty (i.e., risk reduction)
through the pooling of resources to meet uncertain losses. If risks can be spread across a sufficiently large
group, what was for an individual a severe loss from an unexpected/uncertain event becomes a certain
small loss for all members of the group. The uncertainty of possible financial ruin is traded for the
certainty of a manageable loss. The public interest is, in part, a function of how a disaster for an
individual is shared by many (i.e., policyholders).

In public utility regulation, ratemaking has five functions:

(1) Attract investment/participation in the market,
(2) Reasonable pricing,
(3) Incentive to be efficient,
(4) Demand control/consumer rationing, and
(5) Income transfer.

In public utility regulation, rates, legally, must be just, reasonable, and non-discriminatory. To pass
constitutional scrutiny, a rate may not be so low as to be confiscatory. A government-set rate must allow a
regulated company not only to recover its operating expenses, but also to realize reasonable returns
sufficient to ensure confidence in the continued integrity of the company. A rate that does not allow for a
reasonable rate of return is confiscatory and unconstitutional.

The prohibitions against confiscatory government-imposed rates derive from Article I, Section 17 of the
Texas Constitution (“No person’s property shall be taken … for or applied to public use without adequate
compensation being made….”); and the Fifth Amendment to the United States Constitution (“private
property [shall not] be taken for public use, without just compensation”), as applied to the states through
the 14th Amendment.

The Supreme Court of the United States has said, “[t]he guiding principle has been that the Constitution
protects [regulated entities] from being limited to a charge for their property serving the public which is
so ‘unjust’ as to be confiscatory,” a charge that is “‘so unjust as to destroy [the] value of the property for
all the purposes for which it was acquired,’ and in so doing ‘practically deprive[s] the owner of property
without due process of law.’ ” But above this constitutional floor, a rate “may reduce the value of the
property which is being regulated” or “limit stringently the return recovered on investment.”

Broad Trends to Control Total Spending — Massachusetts Law
The state of Massachusetts has established a “health planning council” to catalog “the location,
distribution, and nature of all health care resources” in the state. It then is to develop a “plan to rationally
distribute health care resources … based on the needs of the population.” It has also established an All
Payors Claim Database (APCD) to monitor “charges” and has expanded that APCD to collect information
about organizational structure and internal finances.
Further, there is now a Massachusetts Health Policy Commission charged with overseeing state spending targets. (Mass. Gen. Laws ch. 6D (2012)). Should the state fail to meet the targets set by the commission, the commission may “review the business practices of any provider with excessive expenditures.” If the commission concludes that a change will impair the state’s ability to meet its spending target, it can undertake a cost review and request an investigation by the attorney general into those providers. (Mass. Gen. Laws ch. 6D §13(a)). The commission asked the Massachusetts AG to look into a hospital acquisition of a physician group. The acquisition was permitted, but the hospital agreed to “not raise costs above the rate of inflation for the next six years.” So — one can see — Massachusetts is well on its way to regulating medical/hospital care in a fashion that is similar to a utility.

Patient Perspective

In an effort to inform TMA policy and advocacy, TMA engaged the services of Collective Strength to conduct qualitative research into patient perception of health care costs, charges, and bills. Patients were interviewed in total from Nov. 15 to Nov. 23, 2015, in Bastrop County, Dallas, and Austin.

All focus group participants were insured. The participants were employer-insured, self-insured, or covered by the insurance exchange marketplace. The participants were balanced by political identification (Democrat, Republican, or Independent). Balance by gender, age, and race was also considered.

The focus group feedback indicated that insured Texans understand that health care costs are their responsibility and want to handle these costs correctly. However, they report they can’t get enough information from any source to ensure they know upfront what they are getting themselves into as it may regard medical care. Most participants did believe that if their hospital, clinic, or emergency department (ED) is “in-network,” the professionals who work there and treat them are in-network as well. This presumption was dispelled only when they received a bill from a physician who was not fully paid. Patients report that even when they know about the possibility of balance bills, they still can’t avoid them. The focus group participants reported that they perceive both ED and non-ED balance bills as unfair. In emergency situations, participants said they may have no choice but to enter into a system of care in which they ultimately would receive a balance bill. In non-emergency situations, they see no excuse for such an outcome.

Importantly, the insured Texans who participated in the focus groups did not blame physicians for the issue. They see physicians as highly skilled and “worth the money.” Patients want physicians to set their own rates and participate in the free enterprise system. They don’t want government or politicians making health care system decisions or setting prices.

The focus group participants perceive that physicians work in a highly complex system that is filled with mindless bureaucracy, red tape, complexity, and greed, and they blame the insurance and pharmaceutical companies for it. Nonetheless, the focus group participants expressed a desire for physicians to offer a solution — as the medical profession is trusted while the other stakeholders are not.

Typical participant statements included:

“Even after trying to read up on my insurance plan, I just don’t understand how it works.”

“We shopped ahead of time, and our doctor steered us to an in-network lab. We called the place and were told how much it would be. But when the bills came, it was 10 times more. It was all supposed to be in-network. We are still fighting it for the past 8 months.”

“Insurance is supposed to be simple. It is very, very complex. Communication about costs is just horrible. I am not used to getting all these different bills. Your credit can get ruined, your savings
destroyed. And I have the top-of-the-line plan with a high premium, the most expensive plan they offer. But still they have yet to make it so that people can move on if they get sick.”

“Back in the day, my insurance was paid 100 percent. All you had was a copay and a $2,000 deductible for up to 10 people in your family covered. All the hospitals covered us. I want to go back to that… . Health care needs to be rebooted, and the doctors need to pay attention. It costs too much. If you go to the ER, even for just one hour, you get bills from the hospital, from the doctor, from the radiologist.”

### Traditional and Social Media Reporting on Balance Billing

To gain an understanding of balance billing in all forms of media, TMA engaged the services of Influence Opinions. Their research shows, as compared to the nation as a whole, Texas leads the conversation on balance billing. No single reporter or traditional news outlet has come to “own” the topic of balance billing.

In analyzing social media hashtags associated with balance billing discussions, the top tags centered around Texas legislation:

- #txlege
- #sb481
- #sb425
- #freestandinger
- #medical
- #aarplege

Traditional news and Twitter are most likely to host a discussion of balance billing. However, there were instances where patients used Yelp (an online user review site) to discuss balance billing. Nonetheless, a majority of the balance billing discussion is neutral and informative rather than offering any particular solution. Common themes that appear in these discussions are:

- Physicians provide service to any person who seeks care regardless of ability to pay;
- Need for billing transparency;
- Insurance companies can and will refuse to pay for services, even when in-network;
- Limited physician networks;
- Going to an “in-network” hospital but treated by “out-of-network” doctor; and
- Standard for reimbursement rates.

### Physician Perspective

At the direction of the Task Force chair, TMA staff scheduled meetings with as many county medical society (CMS) executive/economic committees as the calendar would allow. The aim of the meetings were twofold: First, to obtain feedback from CMS leadership regarding the direction or path of TMA legislative/regulatory advocacy on balance billing. Second, to inform CMS leadership of the policy and political environment in regard to balance billing.

TMA staff met with the following societies:

- Bexar CMS
- Big Country CMS
- Dallas CMS
- El Paso CMS
After a short presentation on the policy and political environment, the CMS leadership first generally acknowledged that patients are finding themselves in circumstances where the promise of “financial security” that is supposed to come with insurance is NOT fulfilled, and that patients’ consternation is justified (albeit sometimes misdirected).

Typical statements included:

“The patient perspective is very important.”

“Does anyone disagree that patients have a valid grievance against insurance companies and some physicians who overcharge?”

Feedback from several of the meetings also urged TMA leaders to seek an advocacy position that is in lock-step with patients.

The leadership also expressed an urgency to address this issue:

“This [balance billing] is second only to protecting tort reform in regard to our priorities.”

If we don’t act, “I am worried about free enterprise continuing.”

“We must be very aggressive.”

Many physicians resent that the other stakeholders involved in this issue (e.g., consumer groups, insurance industry, business generally, Republicans, and Democrats) are focusing on physician behavior rather than on the insurance product that is not meeting consumer expectations. Indeed, the passionate indignation at the fact that physicians are cast in a “bad light” for a problem caused by insurers (identified typically as failing to provide an adequate network and settling claims unreasonably) sometimes dominated the policy/advocacy discussion. A number of legislative/regulatory suggestions were made, such as requiring insurers to pay the full charge and mandating the carrier collect the “balance bill.”

Another common legislative/regulatory suggestion was to continue to bolster regulation of insurer networks and force TDI to sanction insurers. It is clear that any legislative strategy that asks physicians to act also must ask insurers, hospitals, and other nonphysician practitioners to act. However, most of the focus of the legislative advocacy discussion was on insurer behavior. For example:

“Insurers should pay fully [it is their product].”

“Insurers have established the contracts and networks that have led to this outcome, they must be held to answer for what they have done.”

As the discussions typically progressed, there was often an acknowledgment that a small number of physicians across specialties may not be billing appropriately. However, there is division as to whether organized medicine should grant government new tools to seek out those who do not conduct themselves honestly. This line of discussion often was used to demonstrate that government holds some blame in the circumstances that face patients. There were some participants who would support legislation authorizing
additional penalties for those who improperly bill (or gouge). However, whenever such a legislative strategy would be discussed, there were other participants who asked:

“Couldn’t anyone just complain about a fee, even if reasonable?”

“What if someone complained about me? What standard would apply?”

Often those who support the concept of increased scrutiny for improper billing would state:

“We need to regulate ourselves.”

“The onus is on us to police ourselves.”

“Opposition to transparency [in charges] is an attempt to take advantage and profit from secrecy. Some must want to hide what they are doing.”

“Being honest and identifying those who are dishonest is part of being a physician.”

When it comes to alternatives for a proactive legislative strategy, and there was again consensus TMA should act and be proactive, there is a split among physicians, and no single solution dominated the discussion.

Statements in support of regulated utility legislative approach

“Distortion in physicians’ fees is caused by corporatized medical groups and associations with hospitals. Costs are four times greater in a hospital versus a clinic.”

“Everyone accepts Medicare. Medicare might provide a good [legislative] benchmark. All private contracts are based on Medicare.”

“Our specialty has discussed this issue and would accept a [legislative] benchmark, but we don’t know what level or percentile at which to set the [legislative] benchmark.”

“Physicians have a hard time running a practice. Maybe it’s appropriate to have someone [in government] set [through legislation] what is reasonable for physician fees.”

Statements in support of a free enterprise legislative approach

“Our position has to be to support physicians and their practices. Regardless of personal beliefs, we have to support balance billing.”

“No one is going to agree [legislatively] to have another entity determine if a fee is reasonable.”

Statements in opposition to use of a database in legislation

“We will lose autonomy if we go down a regulated utility route.”

“We fought SGR. This [benchmark database legislative concept] is worse.”
“Benchmarks are prone to spiraling downward. Consumer indices are inadequate to the task [preventing downward spiral].”

“Any program you hook yourself to [legislatively] will be to your detriment.”

“Why would we put our head in that vice [a benchmark set in statute]?”

Statements in opposition to a legislative approach based upon transparency

“IT simply won’t work and won’t satisfy those who are actually billed.”

“Transparency will not solve the problems we face and that are posed by balance billing.”

“Physicians don’t know what is reasonable and continuing to set charges means some charges will be unreasonable.”

Physician leaders from around the state recognize patients are facing circumstances that they believed insurance would solve. All county societies who met to discuss the issue recognized the need for TMA to respond proactively to the intensity of the political environment. Physician leaders expressed their resentment that the issue of balance billing was being characterized by consumer groups and other stakeholders as a problem of the profession rather than a problem with insurance carriers. The physician leaders wanted to ensure the Board of Trustees that any action demanded of the profession via legislation also must be demanded of hospitals, insurers, and other nonphysician practitioners. However, again, there is no unity on the solution.

TMA has also included a battery of questions regarding balance billing in its January 2016 survey of physicians to obtain the membership’s perspective on legislative solutions that have been put forward by other stakeholders or have become law in other states. Some physicians who received the survey communicated they misunderstood the options presented as legislative solutions TMA had developed. However, to meet the charge of the Task Force, some research on physician attitudes had to be collected.

The survey utilized a forced choice format to discover physician likes and dislikes as it regards various potential legislative proposals. The survey question was as follows:

The Texas Legislature, with encouragement from consumer groups, business and health plans, is likely to entertain a number of bills next session to address the issue. It is likely there will be multiple bills proposed to prohibit out-of-network billing. Note, the Texas Legislature cannot regulate employer-sponsored health plans. The following are provisions that have been proposed or passed in other states.

To address balance billing, if the Texas Legislature or your legislator asked you to choose one of the following to support or agree to next session, which ONE would you want your TMA to support?

The survey revealed that no single solution drew majority support. Physician comments solicited through an open-ended question revealed that physicians were aware of the importance of the issue and the need for TMA to take a legislative position.

Communications to Members and Our Patients

The Task Force was charged to review and/or recommend communications strategies on balance billing. TMA must continue to educate the public/lawmakers on root insurance causes of “surprise bills.” Narrow
networks and an unwillingness to include physicians in all networks (even when contracted) eventually lead to balance bills. TMA should educate physicians (members and nonmembers) on the political realities of a “Just Say No” approach to legislation and the regulatory trend that is sweeping the nation. Once TMA adopts a firm plan of action, public and member communication tactics will build support for that plan.

TMA/physicians must align with patients in their communications. Physicians are trusted by patients, while insurers and other stakeholders are mistrusted or identified as the cause of the problem. Simply, patients don’t “blame” physicians but want them to “fix” the problem (because they trust physicians). Tremendous confusion among patients and the public leads to calls for simplistic legislative “solutions.” In the ED, patients expect high bills, but they also expect insurance to cover more than it does. Also, the ED is not the place for patient education on this issue. By the time a patient reaches an ED, it is too late to offer information, as the patient is focused on the medical concern, not finances.

One-on-one physician-legislator communication on this issue must be enhanced (such as through the implementation of First Tuesday in the District during the interim to begin the cultivation or continuance of a relationship with legislators). The message must be simplified for patients/consumers (infographics, videos, small bites) because an explanation about insurance is complex. Physicians must be armed (especially specialties that perform distinct procedures) with tools to improve patients’ health care finance literacy and to help their patients avoid surprise bills.

To guide its decisionmaking, the Task Force adopted the following principles:

- The recommendations must provide for a unified voice and message.
- The recommendations must continue to protect the right of physicians to bill for out-of-network services.
- The recommendations must align with the best interests of our patients.
- The recommendations must address the behaviors of insurers that finance health care and apply to all practitioners involved in patient care, not merely the medical profession alone.

Based on all of the foregoing, the Board of Trustees recommends adoption of this report to address inadequacies in the insurance products offered to consumers and to protect the right of physicians to bill for their services.

**Recommendation 1:** Adoption of Board of Trustees Report 12-A-16, Improving Network Adequacy and Out-of-Network Billing Policy.

**Recommendation 2:** That the Texas Medical Association advocate legislatively for: (1) mediation for all out-of-network services that is available to patients at all facilities while maintaining the current $500 threshold after copayments, deductibles, and coinsurance as well as mandatory increased state agency oversight of insurers that are often brought to mediation; and (2) development of a standard form for physicians to disclose to patients the identity of other physicians or nonphysician practitioners typically utilized in the facility where the planned surgical procedure or labor and delivery will occur. The form should contain disclaimers for unanticipated complications or events and instruct patients on how they may reach out to those physicians and nonphysician practitioners for further information.
Recommendation 3: Reaffirm and ardently pursue legislative goals in TMA Policy 145.032: Improving Network Adequacy in Health Insurance Plans. This adopted House of Delegates policy, which seeks to hold insurers accountable for their actions, is relevant and essential to success.

Recommendation 4: Refer adopted Board of Trustees Report 12-A-16 to appropriate TMA councils and committees to monitor benchmarking laws and develop needed policy.